

(3) *Amount of inpatient cost sharing requirements.* In fiscal year 2001, the inpatient cost sharing requirements for retirees and their dependents for acute care admissions and other non-mental health/substance use treatment admissions is a per diem charge of \$11, with a minimum charge of \$25 per admission. For mental health/substance use treatment admissions, and for partial hospitalization services, the per diem charge for retirees and their dependents is \$40.

(f) *Limit on out-of-pocket costs under the uniform HMO benefit.* (1) Total out-of-pocket costs per family of dependents of active duty members under the Uniform HMO Benefit may not exceed \$1,000 during the one-year enrollment period. Total out-of-pocket costs per family of retired members, dependents of retired members and survivors under the Uniform HMO Benefit may not exceed \$3,000 during the one-year enrollment period. For this purpose, out-of-pocket costs means all payments required of beneficiaries under paragraphs (c), (d), and (e) of this section. In any case in which a family reaches this limit, all remaining payments that would have been required of the beneficiary under paragraphs (c), (d), and (e) of this section will be made by the program in which the Uniform HMO Benefit is in effect.

(2) The limits established by paragraph (f)(1) of this section do not apply to out-of-pocket costs incurred pursuant to paragraph (m)(1)(i) or (m)(2)(i) of §199.17 under the point-of-service option of TRICARE Prime.

(g) *Updates.* The enrollment fees for fiscal year 2001 set under paragraph (c) of this section and the per service specific dollar amounts for fiscal year 2001 set under paragraphs (d) and (e) of this section may be updated for subsequent years to the extent necessary to maintain compliance with statutory requirements pertaining to government costs. This updating does not apply to cost sharing that is expressed as a percentage of allowable charges; these percentages will remain unchanged.

[60 FR 52101, Oct. 5, 1995, as amended at 63 FR 9143, Feb. 24, 1998; 63 FR 48448, Sept. 10, 1998; 66 FR 9656, Feb. 9, 2001; 66 FR 16400, Mar. 26, 2001]

§ 199.20 Continued Health Care Benefit Program (CHCBP).

(a) *Purpose.* The CHCBP is a premium-based temporary health care coverage program that will be available to beneficiaries who meet the eligibility and enrollment criteria as set forth in paragraph (d)(1) of this section. The CHCBP is not part of the TRICARE program. However, as set forth in this section, it functions under similar rules and procedures of the TRICARE Standard program. Because the purpose of the CHCBP is to provide a continuation health care benefit for the Department of Defense and the other uniformed services (National Oceanic and Atmospheric Administration (NOAA), Public Health Service (PHS), and Coast Guard) beneficiaries losing eligibility, it will be administered so that it appears, to the maximum extent possible, to be part of the TRICARE Standard program. Medical coverage under this program will be the same as the benefits payable under the TRICARE Standard program. However, unlike the Standard program there is a cost for enrollment to the CHCBP and these premium costs are payable by enrollees before any care may be provided.

(b) *General provisions.* Except for any provisions the Director of the TRICARE Management Activity may exclude, the general provisions of §199.1 shall apply to the CHCBP as they do to TRICARE.

(c) *Definitions.* Except as may be specifically provided in this section, to the extent terms defined in §199.2 are relevant to the administration of the CHCBP, the definitions contained in that section shall apply to the CHCBP as they do to the TRICARE Standard program.

(d) *Eligibility and enrollment.* (1) *Eligibility.* Enrollment in the CHCBP is open to any individual, except as noted in this section, who:

(i) Ceases to meet the requirements for eligibility under 10 U.S.C. chapter 55 or 10 U.S.C. 1145, and

(ii) Who on the day before they cease to meet the eligibility requirements for such care they were covered under a health benefit plan under 10 U.S.C. chapter 55 or transitional healthcare under 10 U.S.C. 1145, and

(iii) Who would otherwise not be eligible for any benefits under 10 U.S.C. chapter 55 or 10 U.S.C. 1145 except for CHCBP.

(2) *Exceptions.* The following individuals are not eligible to enroll in CHCBP:

(i) Members of uniformed services, who are discharged or released from active duty either voluntarily or involuntarily under conditions that are adverse.

(ii) Individuals who lost their eligibility or entitlement to care under 10 U.S.C. chapter 55 or 10 U.S.C. 1145 before October 1, 1994.

(iii) Individuals who are locked out of other TRICARE programs per that program's requirements.

(3) *Effective date.* Eligibility in the CHCBP is limited to individuals who lost their entitlement to benefits under the MHS on or after October 1, 1994. The effective date of their coverage under CHCBP shall begin on the day after they cease to be eligible for care under 10 U.S.C. chapter 55 or 10 U.S.C. 1145.

(4) *Notification of eligibility.*

(i) The Department of Defense and the other uniformed services (National Oceanic and Atmospheric Administration (NOAA), Public Health Service (PHS), and Coast Guard) will notify persons in the uniformed services eligible to receive health benefits under the CHCBP. In the case of a member who becomes (or will become) eligible for continued coverage, the Department of Defense shall notify the member of their rights for coverage as part of pre-separation counseling conducted under 10 U.S.C. 1142.

(ii) In the case of a dependent of a member or former member who become eligible for continued coverage under paragraph (d)(1)(ii) of this section:

(A) The member or former member may submit to the CHCBP contractor a notice with supporting documentation of the dependent's change in status (including the dependent's name, address, and such other information needed); and

(B) The CHCBP contractor, within fourteen (14) days after receiving such information, will inform the dependent of the dependent's rights under 10 U.S.C. 1142.

(iii) In the case of a former spouse of a member or former member who becomes eligible for continued coverage, the member, former member or former spouse may submit to the CHCBP contractor a notice of the former spouse's change in status. The CHCBP contractor within fourteen (14) days after receiving such information will notify the individual of their potential eligibility for CHCBP.

(5) *Election of coverage.* In order to obtain coverage under the CHCBP, a written election by the eligible beneficiary must be made within a prescribed time period.

(i) In the case of a member discharged or released from active duty or full-time National Guard duty (whether voluntarily or involuntarily), or a RC member formerly eligible for care under 10 U.S.C. chapter 55, the written election shall be submitted to the CHCBP contractor before the end of the 60-day period beginning on the later of:

(A) The date of the discharge or release of the member; or

(B) The date that the period of transitional health care applicable to the member under 10 U.S.C. 1145(a) ends; or

(C) The date the member receives the notification required in paragraph (d)(3) of this section.

(ii) In the case of a child who ceases to meet the requirements for being an unremarried dependent child of a member or former member under 10 U.S.C. 1072(2)(D) or an unmarried dependent of a member or former member of the uniformed services under 10 U.S.C. 1072(2)(I), the written election shall be submitted to the CHCBP contractor before the end of the 60-day period beginning on the later of:

(A) The date that the dependent ceases to meet the definition of a dependent under 10 U.S.C. 1072(2)(D) or 10 U.S.C. 1072(2)(I); or

(B) The date that the dependent receives the notification required in paragraph (d)(3) of this section,

(iii) In the case of former spouse of a member or former member, the written election shall be submitted to the CHCBP contractor before the end of the 60-day period beginning on the date as of which the former spouse first ceases to meet the requirements for

being considered a dependent under 10 U.S.C. 1072(2).

(iv) In the case of an unmarried surviving spouse of a member or former member of the uniformed services who on the day before the death of the member or former member was covered under 10 U.S.C. chapter 55 or 10 U.S.C. 1145(a), the written election shall be submitted to the CHCBP contractor within 60 days of the date of the member or former member's death.

(v) A member of the uniformed services who is eligible for enrollment under paragraph (d)(1) of this section may elect self-only or family coverage. Family members who may be included in such family coverage are the spouse and children of the member.

(vi) All other categories eligible for enrollment under paragraph (d)(1) of this section must elect self-only coverage.

(6) *Enrollment.* To enroll in the CHCBP, an eligible individual must submit the completed enrollment form designated by the Director, TRICARE as well as any documentation as requested on the enrollment form to verify the applicant's eligibility for enrolling in CHCBP, and payment to cover the quarter's premium. The CHCBP contractor may request additional information and documentation to confirm the applicant's eligibility for CHCBP.

(7) *Period of coverage.* Except as noted below CHCBP coverage may not extend beyond 18 months from the date the individual becomes eligible for CHCBP. Although beneficiaries have sixty (60) days to elect coverage under the CHCBP, upon enrolling, the period of coverage must begin the day after entitlement or eligibility to a military health care plan ends as though no break in coverage had occurred notwithstanding the date the enrollment form with any applicable premium is submitted.

(i) *Exceptions:*

(A) In the case of a child of a member or former member, the date which is 36 months after the date on which the person first ceases to meet the requirements for being considered an unmarried dependent child under 10 U.S.C. 1072(2)(D) or 10 U.S.C. 1072(2)(I).

(B) In the case of an unmarried former spouse (as this term is defined in 10 U.S.C. 1072(2)(G) or (H)) of a member or former member, the date which is 36 months after the later of:

(1) The date on which the final decree of divorce, dissolution, or annulment occurs; or

(2) If applicable, the date the one-year extension of dependency under 10 U.S.C. 1072(2)(H) expires.

(C) In the case of an unmarried surviving spouse (widow or widower) (under 10 U.S.C. 1072(2)(B) or (C)) of a member or former member of the uniformed services who is not otherwise eligible for care under 10 U.S.C. chapter 55, the date which is 36 months after the date the surviving spouse becomes ineligible under 10 U.S.C. chapter 55 or 10 U.S.C. 1145(a).

(D) In the case of a former spouse of a retiree whose marriage was dissolved after the member retired from the service, the period of coverage under the CHCBP is unlimited, if the former spouse:

(1) Has not remarried before the age of 55 after the marriage to the former member was dissolved; and

(2) Was enrolled in the CHCBP or TRICARE as the dependent of a retiree during the 18-month period before the date of the divorce, dissolution, or annulment; and

(3) Is receiving a portion of the retired or retainer pay of a member or former member or an annuity based on the retainer pay of the member; or

(4) Has a court order for payment of any portion of the retired or retainer pay or has a written agreement (whether voluntary or pursuant to a court order) which provides for an election by the member or former member to provide an annuity to the former spouse.

(E) For the beneficiary who becomes eligible for the CHCBP by ceasing to meet the requirements for being considered an unmarried dependent child of a member or former member, health care coverage may not extend beyond the date which is 36 months after the date the member becomes ineligible for medical and dental care under 10 U.S.C. 1074(a) and any transitional health care under 10 U.S.C. 1145(a).

(e) *CHCBP benefits*—(1) *In general.* Except as provided in paragraph (e)(2) of this section, the provisions of §199.4 shall apply to the CHCBP as they do to TRICARE.

(2) *Exceptions.* The following provisions of §199.4 are not applicable to the CHCBP:

(i) Section 199.4(a)(2) concerning eligibility.

(ii) All provisions regarding requirements to use facilities of the uniformed services because CHCBP enrollees are not eligible to use those facilities.

(3) *Beneficiary liability.* For purposes of TRICARE deductible and cost-sharing requirements and catastrophic cap limits, amounts applicable to the category of beneficiaries to which the CHCBP enrollee last belonged shall continue to apply, except that for separating active duty members, amounts applicable to dependents of active duty members shall apply.

(f) *Authorized providers.* The provisions of §199.6 shall apply to the CHCBP as they do to TRICARE Standard.

(g) *Claims submission, review, and payment.* The provisions of §199.7 shall apply to the CHCBP as they do to TRICARE Standard except no provisions regarding nonavailability statements shall apply.

(h) *Double coverage.* The provisions of §199.8 shall apply to the CHCBP as they do to TRICARE Standard.

(i) *Administrative remedies for fraud, abuse, and conflict of interest.* The provisions of §199.9 shall apply to the CHCBP as they do to TRICARE Standard.

(j) *Appeal and hearing procedures.* The provisions of §199.10 shall apply to the CHCBP as they do to TRICARE Standard.

(k) *Overpayments recovery.* The provisions of §199.11 shall apply to the CHCBP as they do to TRICARE Standard.

(l) *Third party recoveries.* The provisions of §199.12 shall apply to the CHCBP as they do to TRICARE Standard.

(m) *Provider reimbursement methods.* The provisions of §199.14 shall apply to the CHCBP as they do to TRICARE Standard.

(n) *Quality and Utilization Review Peer Review Organization Program.* The provisions of §199.15 shall apply to the CHCBP as they do to TRICARE Standard.

(o) *Preferred provider organization programs available.* Any preferred provider organization program under this part that provides for reduced cost sharing for using designated providers, such as the “TRICARE Extra” option under §199.17, shall be available to participants in the CHCBP as it is to TRICARE Standard beneficiaries.

(p) *Special programs not applicable*—(1) *In general.* Special programs established under this Part that are not part of the TRICARE Standard program established pursuant to 10 U.S.C. 1079 and 1086 are not, unless specifically provided in this section, available to participants in the CHCBP.

(2) *Examples.* The special programs referred to in paragraph (p)(1) of this section include but are not limited to:

(i) The Extended Care Health Option under §199.5;

(ii) The TRICARE Dental Program or Retiree Dental Program under §199.13 and 199.22 respectively;

(iii) The Supplemental Health Care Program under §199.16;

(iv) The TRICARE Program under §199.17, except for TRICARE Standard and Extra programs under that section; and

(v) The Uniform HMO benefit under §199.18.

(q) *Premiums*—(1) *Rates.* Premium rates will be established by the Assistant Secretary of Defense (Health Affairs) for two rate groups—individual and family. Eligible beneficiaries will select the level of coverage they require at the time of initial enrollment (either individual or family) and pay the appropriate premium payment. The rates are based on Federal Employees Health Benefits Program employee and agency contributions required for a comparable health benefits plan, plus an administrative fee. The administrative fee, not to exceed ten percent of the basic premium amount, shall be determined based on actual expected administrative costs for administration of the program. Premiums may be revised annually and shall be published when the premium amount is changed.

Premiums will be paid by enrollees quarterly.

(2) *Effects of failure to make premium payments.* Failure by enrollees to submit timely and proper premium payments will result in denial of continued enrollment and denial of payment of medical claims. Premium payments that are late thirty (30) days or more past the start of the quarter for which payment is due will result in the termination of beneficiary enrollment. Beneficiaries denied continued enrollment due to lack of premium payments will not be allowed to reenroll. In such a case, benefit coverage will cease at the end of the ninety (90) day period for which a premium payment was received. Enrollees will be held liable for medical costs incurred after losing eligibility.

(r) *Procedures.* The Director, TRICARE Management Activity, may establish other rules and procedures for the administration of the CHCBP.

[76 FR 57639, Sept. 16, 2011]

§ 199.21 TRICARE Pharmacy Benefits Program.

(a) General—(1) *Statutory authority.* Title 10, U.S. Code, Section 1074g requires that the Department of Defense establish an effective, efficient, integrated pharmacy benefits program for the Military Health System. This law is independent of a number of sections of Title 10 and other laws that affect the benefits, rules, and procedures of TRICARE, resulting in changes to the rules otherwise applicable to TRICARE Prime, Standard, and Extra.

(2) *Pharmacy benefits program.* (i) *Applicability.* The pharmacy benefits program, which includes the uniform formulary and its associated tiered co-payment structure, is applicable to all of the uniformed services. Geographically, except as specifically provided in paragraph (a)(2)(ii) of this section, this program is applicable to all 50 states and the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. In addition, if authorized by the Assistant Secretary of Defense (Health Affairs) (ASD(HA)), the TRICARE pharmacy benefits program may be implemented in areas outside the 50 states and the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. In such

case, the ASD (HA) may also authorize modifications to the pharmacy benefits program rules and procedures as may be appropriate to the area involved.

(ii) *Applicability exception.* The pharmaceutical benefit under the TRICARE smoking cessation program under § 199.4(e)(30) is available to TRICARE beneficiaries who are not entitled to Medicare benefits authorized under Title XVIII of the Social Security Act. Except as noted in § 199.4(e)(30), the smoking cessation program, including the pharmaceutical benefit, is not applicable or available to beneficiaries who reside overseas, including the U. S. territories of Guam, Puerto Rico, and the Virgin Islands, except that under the authority of § 199.17 active duty service members and active duty dependents enrolled in TRICARE Prime residing overseas, including the U. S. territories of Guam, Puerto Rico, and the Virgin Islands, shall have access to smoking cessation pharmaceuticals through either an MTF or the TMOP program where available.

(3) *Uniform formulary.* The pharmacy benefits program features a uniform formulary of pharmaceutical agents as defined in § 199.2.

(i) The uniform formulary will assure the availability of pharmaceutical agents in the complete range of therapeutic classes authorized as basic program benefits.

(ii) As required by 10 U.S.C. 1074g(a)(2) and implemented under the procedures established by paragraphs (e) and (f) of this section, pharmaceutical agents in each therapeutic class are selected for inclusion on the uniform formulary based upon the relative clinical effectiveness and cost effectiveness of the agents in such class. If a pharmaceutical agent in a therapeutic class is determined by the Department of Defense Pharmacy and Therapeutics Committee not to have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome over other pharmaceutical agents included on the uniform formulary, the Committee may recommend it be classified as a non-formulary agent. In addition, if the evaluation by the Pharmacy and Therapeutics Committee concludes that a pharmaceutical agent